FOR OHF USE

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0020610

Facility Name: Wabash Christian Retirement

Address: 216 College Blvd. (Number) Carmi (City) 62821 (Zip Code)

County: White

Telephone Number: 618-382-4644 **Fax #** ( )

IDPA ID Number: 37-0841562002

Date of Initial License for Current Owners: 1974

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501(C)3		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: William O. Buskirk **Telephone Number:** 217-525-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from July 1, 1999 to June 30, 2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Mark Havrilka
(Title) Chief Financial Officer

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) William E. Castor, III, CPA
(Firm Name & Address) Eck, Schafer & Punke, LLP 600 East Adams Springfield, IL 62701-1624
(Telephone) 217-525-1111 Fax # 217-525-1120

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	160	Skilled (SNF)	160	58,400	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	160	TOTALS	160	58,400	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	23,302	10,234		33,536	8
9	SNF/PED					9
10	ICF	11,710	6,605		18,315	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	35,012	16,839		51,851	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.79%

D. How many bed-hold days during this year were paid by Public Aid?
20 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 06/01/74

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [x] If YES, enter number of beds certified and days of care provided

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 06/30/00 Fiscal Year: 06/30/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Wabash Christian Retirement # 0020610 **Report Period Beginning:** July 1, 1999 **Ending:** June 30, 2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	224,422	24,854	12,074	261,350	(1,276)	260,074		260,074			1
2	Food Purchase		213,938		213,938		213,938	(59)	213,879			2
3	Housekeeping	92,761	32,014	61	124,836	(61)	124,775		124,775			3
4	Laundry	111,635	26,483		138,118		138,118		138,118			4
5	Heat and Other Utilities			127,509	127,509		127,509	696	128,205			5
6	Maintenance	52,652	40,809	44,946	138,407	(514)	137,893	6,727	144,620			6
7	Other (specify):*											7
8	**TOTAL General Services**	481,470	338,098	184,590	1,004,158	(1,851)	1,002,307	7,364	1,009,671			8
	B. Health Care and Programs											
9	Medical Director			3,050	3,050		3,050		3,050			9
10	Nursing and Medical Records	1,553,262	74,823	15,282	1,643,367	(6,030)	1,637,337		1,637,337			10
10a	Therapy			10,197	10,197		10,197		10,197			10a
11	Activities	28,724		400	29,124		29,124		29,124			11
12	Social Services	78,333	1,128	859	80,320	(859)	79,461		79,461			12
13	Nurse Aide Training											13
14	Program Transportation		2,249		2,249		2,249		2,249			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,660,319	78,200	29,788	1,768,307	(6,889)	1,761,418		1,761,418			16
	C. General Administration											
17	Administrative	49,235	1,045	170,412	220,692		220,692	(135,233)	85,459			17
18	Directors Fees											18
19	Professional Services			460	460		460	19,115	19,575			19
20	Dues, Fees, Subscriptions & Promotions			17,642	17,642		17,642	(5,062)	12,580			20
21	Clerical & General Office Expenses	54,447	4,194	20,159	78,800	(1,411)	77,389	4,943	82,332			21
22	Employee Benefits & Payroll Taxes			332,956	332,956		332,956	4,859	337,815			22
23	Inservice Training & Education											23
24	Travel and Seminar					11,761	11,761	2,573	14,334			24
25	Other Admin. Staff Transportation			1,610	1,610	(1,610)						25
26	Insurance-Prop.Liab.Malpractice			14,243	14,243		14,243	1,412	15,655			26
27	Other (specify):*											27
28	**TOTAL General Administration**	103,682	5,239	557,482	666,403	8,740	675,143	(107,393)	567,750			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,245,471	421,537	771,860	3,438,868		3,438,868	(100,029)	3,338,839			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Wabash Christian Retirement #0020610 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			127,614	127,614		127,614	(12,560)	115,054			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			103,881	103,881		103,881	(11,465)	92,416			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* **Financing Fee**			5,071	5,071		5,071		5,071			36
37	**TOTAL Ownership**			236,566	236,566		236,566	(24,025)	212,541			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			44	44		44		44			39
40	Barber and Beauty Shops			8,379	8,379		8,379		8,379			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			87,840	87,840		87,840		87,840			42
43	Other (specify):* **Apt/Congregate**			98,792	98,792		98,792		98,792			43
44	**TOTAL Special Cost Centers**			195,055	195,055		195,055		195,055			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,245,471	421,537	1,203,481	3,870,489		3,870,489	(124,054)	3,746,435			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(59)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(20,283)	30		9
10	Interest and Other Investment Income	(6,552)	32		10
11	Discounts, Allowances, Rebates & Refunds	(6,336)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(4,913)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	36	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(3,820)	21		24
25	Fund Raising, Advertising and Promotional	(6,071)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(9,835)	21		28
29	Other-Attach Schedule	29			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (57,804)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(66,250)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (66,250)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (124,054)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Wabash Christian Retirement

ID# 0020610

Report Period Beginning: July 1, 1999

Ending: June 30, 2000

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending	$ 47	21	1
2	Activities	(16)	21	2
3	Miscellaneous revenue	(2)	21	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	29		90

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Wabash Christian Retirement # 0020610 **Report Period Beginning:** July 1, 1999 **Ending:** June 30, 2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(59)	0	0	0	0	0	0	0	0	0	0	(59)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	696	0	0	0	0	0	0	0	0	0	696	5
6	Maintenance	0	6,727	0	0	0	0	0	0	0	0	0	6,727	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(59)	7,423	0	0	0	0	0	0	0	0	0	7,364	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(135,233)	0	0	0	0	0	0	0	0	0	(135,233)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	19,115	0	0	0	0	0	0	0	0	0	19,115	19
20	Fees, Subscriptions & Promotions	(6,071)	1,009	0	0	0	0	0	0	0	0	0	(5,062)	20
21	Clerical & General Office Expenses	(19,926)	24,869	0	0	0	0	0	0	0	0	0	4,943	21
22	Employee Benefits & Payroll Taxes	0	4,859	0	0	0	0	0	0	0	0	0	4,859	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	2,573	0	0	0	0	0	0	0	0	0	2,573	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	1,412	0	0	0	0	0	0	0	0	0	1,412	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(25,997)	(81,396)	0	0	0	0	0	0	0	0	0	(107,393)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(26,056)	(73,973)	0	0	0	0	0	0	0	0	0	(100,029)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Wabash Christian Retirement # 0020610 **Report Period Beginning:** July 1, 1999 **Ending:** June 30, 2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(20,283)	7,723	0	0	0	0	0	0	0	0	0	(12,560)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(11,465)	0	0	0	0	0	0	0	0	0	0	(11,465)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(31,748)	7,723	0	0	0	0	0	0	0	0	0	(24,025)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(57,804)	(66,250)	0	0	0	0	0	0	0	0	0	(124,054)	45

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Schedule						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [x] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Christian Homes, Inc.	100.00%	$ 696	$ 696	1
2	V	6	Maintenance				6,727	6,727	2
3	V	17	Administrative	170,412			35,179	(135,233)	3
4	V	18	Directors						4
5	V	19	Professional Services				19,115	19,115	5
6	V	20	Fees/Subscription/Promotion				1,009	1,009	6
7	V	21	Clerical				24,869	24,869	7
8	V	22	Employee Benefits	6,507			11,366	4,859	8
9	V	23	In-Service						9
10	V	24	Travel and Seminar				2,573	2,573	10
11	V	26	Insurance				1,412	1,412	11
12	V	21	Homan Resources						12
13	V	30	Depreciation				7,723	7,723	13
14	Total			$ 176,919			$ 110,669	$ * (66,250)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	This workpaper is not applicable.								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 1999 Ending: ne 30, 2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		This worksheet is not applicable.				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	City of Carmi (Tax Exempt)		x	Refinance Mortgage	$19,485.00	01/01/90	$ 2,185,000	$ 1,220,750	01/01/10	0.0750	$ 93,338	1
2	Due to CHI Bond Fund	x			$2,500.00	09/01/97	70,000	0	09/01/01	0.0850	5,630	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$21,985.00		$ 2,255,000	$ 1,220,750			$ 98,968	9
	B. Non-Facility Related*											
10	City of Carmi		x	Refinance Mortgage	$1,026.00	01/01/90	115,000	64,250	01/01/10	0.0750	4,913	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related				$1,026.00		$ 115,000	$ 64,250			$ 4,913	14
15	TOTALS (line 9+line14)						$ 2,370,000	$ 1,285,000			$ 103,881	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	This W/S is N/	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$	#VALUE!	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	#VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 60,480 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

Duplex Building

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	217,800	1974	$ 65,910	1
2	Home Office			6,624	2
3	TOTALS	217,800		$ 72,534	3

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	80		1974	1958	$ 1,127,971	$ 26,010	17	$ 2,937	$ (23,073)	$ 1,127,971	4
5	80		1976	1976	637,282	18,121	30	21,243	3,122	224,921	5
6											6
7											7
8	Home Office				47,271	1,544		1,544		20,523	8
	Improvement Type**										
9	Land Improvement			1974	10,000		20			10,000	9
10	Land Improvement			1978	671		20			671	10
11	Building			1978	13,972	399	35	399		10,020	11
12	Building Improvements			1979	36,485		18			36,485	12
13	Land Improvement			1979	1,010		5			1,010	13
14	Land Improvement			1979	1,782		5			1,782	14
15	Boiler Room			1981	3,648	3	15	3		3,648	15
16											16
17											17
18	Landscaping			1981	6,683		10			6,683	18
19	Roof Repairs			1981	4,080		3			4,080	19
20	Building Improvements			1982	19,950	798	25	798		13,843	20
21	Electrical Supplies			1982	234	12	20	12		217	21
22	Rewiring Westside			1982	3,000	150	20	150		2,713	22
23	Guttering			1982	9,567		15			9,567	23
24	Wallcovering			1982	1,750		10			1,750	24
25	TV Systems			1982	2,090	5	15	5		2,090	25
26	Heating Control Systems			1982	34,046	1,702	20	1,702		30,920	26
27	Light Fixtures			1984	1,432	2	10	2		1,432	27
28	Floor Tile			1985	6,641	1	10	1		6,641	28
29	Vinyl & Labor			1985	397		10			397	29
30											30
31	Sewer Work			1985	20,976	699	30	699		10,543	31
32	Nurse Station			1985	7,623	381	20	381		5,620	32
33	Hot Water Heaters			1986	4,900	327	15	327		4,632	33
34	Nurse Call Systems			1986	1,179	79	15	79		1,165	34
35	Roofwork			1986	7,235	482	15	482		6,989	35
36	TOTAL (lines 4 thru 35)				$ 2,011,875	$ 50,715		$ 30,764	$ (19,951)	$ 1,546,313	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Boiler System			1986	6,061	303	20	303		4,242	9
10	Grading			1987	1,470	74	20	74		962	10
11	Floor Tile			1987	977		10			977	11
12	Bathroom Remodel			1987	5,615	281	20	281		3,770	12
13	Wallpaper			1988	870		5			870	13
14	Carpeting			1989	1,086		5			1,086	14
15	Carpeting			1989	800		5			800	15
16	Painting & Papering			1989	856		5			856	16
17	Painting			1989	467	1	5		(1)	467	17
18	Light Fixtures (28)			1989	1,341	34	10	34		1,341	18
19	Rooftop A/C Unit (2)			1989	6,280		8			6,280	19
20	Roof			1989	81,902	4,095	20	4,095		42,998	20
21	Tile			1990	1,231	1	5	1		1,231	21
22	Faucets			1990	1,716	139	10	139		1,716	22
23	Carpeting			1990	3,236	1	5	1		3,236	23
24	Carpeting			1990	2,392	2	5	2		2,392	24
25	Carpeting			1990	2,298		5			2,298	25
26	Carpeting			1990	2,799		5			2,779	26
27	Rooftop A/C Unit (2)			1991	4,080		8			4,080	27
28	Fill and Seal Parking Lot			1991	2,779		5			2,779	28
29	Condensing Unit			1991	1,355	136	10	136		1,213	29
30	Steel Doors			1991	1,650	110	15	110		972	30
31	New Roof			1991	11,931	795	15	795		6,956	31
32	Light Fixtures			1991	2,189	219	10	219		1,880	32
33											33
34	Remodel 22 Bathrooms			1992	10,313	516	20	516		4,343	34
35	Steel Doors			1992	1,650	110	15	110		926	35
36	TOTAL (lines 4 thru 35)				$ 157,344	$ 6,817		$ 6,816	$ (1)	$ 101,450	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Wallpaper			1992	1,695		5			1,695	9
10	Remodel Lobby/Dining Room			1992	12,246	612	20	612		4,284	10
11	Remodel Bathrooms			1992	2,331	117	20	117		975	11
12	Carpeting			1992	2,480		5			2,480	12
13	Rooftop A/C Unit			1992	5,338	502	8	502		5,338	13
14	Carpeting			1992	3,166	1	5	1		3,166	14
15	A/C Units			1992	1,700		5			1,700	15
16	Remodeling			1992	11,834	592	20	592		4,736	16
17	Sound System			1992	1,563	156	10	156		1,222	17
18	Water Heater			1992	1,862	124	15	124		961	18
19	Remodeling			1993	6,615	662	20	331	(331)	2,354	19
20	Wallcovering/base Trim			1993	2,123		5			2,123	20
21	Sidewalk			1993	2,395	160	15	160		1,147	21
22	Garage Door			1993	848	85	10	85		574	22
23											23
24	New Roof Beauty Shop			1993	4,515	301	15	301		1,982	24
25	Rheem Water Heater			1994	2,270	227	10	227		1,438	25
26	Door			1994	1,365	137	10	137		856	26
27	Fire Alarm System			1994	26,850	1,343	20	1,343		8,170	27
28	Driveway			1994	2,628	175	15	175		1,006	28
29	Egress Locks			1994	2,298	230	10	230		1,303	29
30	Carpeting			1995	545	73	5	73		545	30
31	Kitchen			1995	85,264	2,750	31	2,750		14,346	31
32	Conc. Trought-Laundry			1995	1,183	118	10	118		620	32
33	Remodel Wing			1995	9,535	1,589	5	1,589		9,535	33
34	Rooftop A/C Unit Eastside			1995	1,800	180	10	180		870	34
35	Remodel Wing 8			1996	8,911	1,782	5	1,782		7,597	35
36	TOTAL (lines 4 thru 35)				$ 203,360	$ 11,916		$ 11,585	$ (331)	$ 81,023	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Tile Kitchen			1997	2,304	461	5	461		1,575	9
10	Double Doors			1997	736	147	5	147		465	10
11	Resurface Parking Lot			1997	14,035	4,678	3	4,678		14,034	11
12	Resurface Employee Parking Lot			1997	8,000	1,600	5	1,600		4,267	12
13	Waterfall			1998	908	182	5	182		425	13
14	Activity Bathroom			1998	6,101	1,220	5	1,220		2,745	14
15	Landscaping - Courtyard			1998	1,202	240	5	240		483	15
16	Security Door			1999	984	197	5	197		378	16
17	Remodeling			1999	5,600	1,120	5	1,120		1,960	17
18	Carpeting			1999	903	181	5	181		226	18
19	Congoleum Flooring			2000	3,540	590	5	590		590	19
20	Paint (Wing 4)			2000	3,153	421	5	421		421	20
21	Vinyl Floor Covering			2000	1,770	266	5	266		266	21
22	Vinyl Floor			2000	720	72	5	72		72	22
23	Border & Wallpaper			2000	736	74	5	74		74	23
24	Kitchen Vinyl			2000	725	48	5	48		48	24
25	Handrails (58)			2000	1,283	7	15	7		7	25
26	3 1/2 ton A/C (Wing 3)			2000	1,900	32	5	32		32	26
27	Trane Furnance and A/C System (Wing 2)			2000	8,164	45	15	45		45	27
28	Lamenate Flooring (Bath and Kitchen)			2000	2,091	17	10	17		17	28
29	Carpet			2000	1,822	61	5	61		61	29
30	Asphalt-Parking Lot			2000	7,440	1,364	5	1,364		1,364	30
31	Rock for Water Garden			2000	604	5	10	5		5	31
32	Aquarium-Sere Garden			2000	1,704	57	10	57		57	32
33	Barn 12 x 18			2000	3,000	200	10	200		200	33
34	Administative wing remodeling/addition			2000	236,993		40				34
35											35
36	TOTAL (lines 4 thru 35)				$ 316,418	$ 13,285		$ 13,285	$	$ 29,817	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 434,379	$ 45,201	$ 45,201	$		$ 241,035	37
38	Current Year Purchases	14,590	1,224	1,224			1,224	38
39	Fully Depreciated Assets	115,533					115,533	39
40	Home Office	41,260	4,259	4,259			33,549	40
41	TOTALS	$ 605,762	$ 50,684	$ 50,684	$		$ 391,341	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Patient Transport	1993 Ford Bus	1993	$ 39,450	$	$	$	5	$ 39,450	42
43										43
44										44
45	Home Office			3,985	1,920	1,920		5	2,770	45
46	TOTALS			$ 43,435	$ 1,920	$ 1,920	$		$ 42,220	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 3,410,728	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 135,337	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 115,054	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (20,283)	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 2,192,164	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Apartments & Triplex	$ 435,747	$ 12,417	$ 184,354	52
53	Apt. Equipment	520	104	225	53
54	Carport	26,000	1,300	7,700	54
55	Land Improvement	2,859	193	1,364	55
56					56
57	TOTALS	$ 465,126	$ 14,014	$ 193,643	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- COMMUNITY COLLEGE ☐
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$ Not Applicable		$	$		$ #VALUE!	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$ #VALUE!	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XV. BALANCE SHEET - Unrestricted Operating Fund. As of June 30, 2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 73,113	$	1
2	Cash-Patient Deposits	14,489		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 26,616)	274,814		3
4	Supply Inventory (priced at FIFO)	33,631		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued Int Rec	971		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 397,017	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	65,910		13
14	Buildings, at Historical Cost	2,777,167		14
15	Leasehold Improvements, at Historical Cost	92,171		15
16	Equipment, at Historical Cost	604,857		16
17	Accumulated Depreciation (book methods)	(2,099,076)		17
18	Deferred Charges	23,599		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,312,571		21
22	Other Long-Term Assets (spCIP	236,607		22
23	Other(specify): Contract Receivable	18,355		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,032,161	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,429,178	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 57,238	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,489		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	150,694		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	82,581		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 305,002	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	1,285,000		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Resident Deposits	97,973		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,382,973	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,687,975	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,741,203	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,429,178	$	48

***(See instructions.)**

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$	1
2	Restatements (describe):	1,689,182	2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,689,182	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	52,021	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 52,021	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,741,203	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,529,034	1
2	Discounts and Allowances for all Levels	(902,066)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,626,968	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,249	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,249	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	150	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	10,592	13
14	Non-Patient Meals	59	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	87	19
20	Radiology and X-Ray		20
21	Other Medical Services	(66)	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 10,822	23
	D. Non-Operating Revenue		
24	Contributions	60,235	24
25	Interest and Other Investment Income***	31,853	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 92,088	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Residential/Congregate**	198,419	28
28a	**Unrealized Investment loss and Equipment sale loss**	(8,036)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 190,383	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,922,510	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,004,158	31
32	Health Care	1,768,307	32
33	General Administration	666,403	33
	B. Capital Expense		
34	Ownership	236,566	34
	C. Ancillary Expense		
35	Special Cost Centers	8,423	35
36	Provider Participation Fee	87,840	36
	D. Other Expenses (specify):		
37	**Apartment/ Congregate**	98,792	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,870,489	40
41	**Income before Income Taxes (line 30 minus line 40)****	52,021	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 52,021	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,702	1,882	$ 39,169	$ 20.81	1
2	Assistant Director of Nursing	1,882	2,081	34,765	16.71	2
3	Registered Nurses	11,343	12,545	241,352	19.24	3
4	Licensed Practical Nurses	31,096	34,391	440,149	12.80	4
5	Nurse Aides & Orderlies	89,377	98,846	764,284	7.73	5
6	Nurse Aide Trainees		0			6
7	Licensed Therapist		0			7
8	Rehab/Therapy Aides	3,744	4,141	33,543	8.10	8
9	Activity Director	1,441	1,594	13,878	8.71	9
10	Activity Assistants	975	1,078	14,846	13.77	10
11	Social Service Workers	7,634	8,443	78,333	9.28	11
12	Dietician		0			12
13	Food Service Supervisor		0			13
14	Head Cook		0			14
15	Cook Helpers/Assistants	25,522	28,226	224,422	7.95	15
16	Dishwashers		0			16
17	Maintenance Workers	3,785	4,186	52,652	12.58	17
18	Housekeepers	11,217	12,405	92,761	7.48	18
19	Laundry	11,639	12,872	111,635	8.67	19
20	Administrator	1,629	1,802	49,235	27.32	20
21	Assistant Administrator		0			21
22	Other Administrative		0			22
23	Office Manager	1,704	1,885	29,086	15.43	23
24	Clerical	2,937	3,248	25,361	7.81	24
25	Vocational Instruction		0			25
26	Academic Instruction		0			26
27	Medical Director		0			27
28	Qualified MR Prof. (QMRP)		0			28
29	Resident Services Coordinator		0			29
30	Habilitation Aides (DD Homes)		0			30
31	Medical Records		0			31
32	Other Health Care(specify)		0			32
33	Other(specify)		0			33
34	TOTAL (lines 1 - 33)	207,627	229,625	$ 2,245,471 *	$ 9.78	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	249	$ 10,799	1.3	35
36	Medical Director	6	3,050	9.3	36
37	Medical Records Consultant	48	2,282	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	164	720	10.3	39
40	Physical Therapy Consultant	112	7,966	10A.3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	30	2,231	10A.3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Dental		245		46
47					47
48					48
49	TOTAL (lines 35 - 48)	609	$ 27,293		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Arthur Saunders	Administrator	0%	$ 49,235
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 49,235

B. Administrative - Other

Description	Amount
Management Fee	$ 170,412
TOTAL (agree to Schedule V, line 17, col. 3)	$ 170,412
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Stanley Law	Legal	$ 10
Hamtek	Computer	50
Lloyd Stills Realty	Appraisal	400
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 460

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 59,820
Unemployment Compensation Insurance	6,507
FICA Taxes	162,130
Employee Health Insurance	94,050
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	0
Employee Expense	8,382
Employee Physicals	939
Employee Uniforms	296
Workers' comp. Medical expenses	832
Home Office Allocation	11,366
Related party adjustment	(6,507)
TOTAL (agree to Schedule V, line 22, col.8)	$ 337,815

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,912
Health Care Worker Background Check	
(Indicate # of checks performed)	
Subscriptions	788
Fees	1,382
Dues	7,489
Promotion	6,071
Home Office Allocation	1,009
Less: Public Relations Expense	(6,071)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,580

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 747
In-State Travel	3,410
Seminar Expense	7,604
Home Office Allocation	2,573
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14,334

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
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9													
10													
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12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 1999 Ending: June 30, 200

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **L.S.N. $6,761**

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **8**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,631** Line **10.2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **87,840**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **59**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **0**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ 0

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Eck, Schafer & Punke, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **To be provided upon completion.**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.